The Future Direction of Medicaid Long Term Care Services in Virginia

The Department of Medical Assistance Services has been working with Governor Kaine's office to develop options for Medicaid reform in Virginia. The key option we will be pursuing under his direction is the integration of acute care and long-term care services for our elderly and disabled clients. Below is an excerpt from his recent address to the General Assembly and portions of a background paper he was provided on the subject.

Governor Kaine's Address to the Joint Assembly: Health Care

January 16, 2006

For our economy to continue to thrive, we must also address the threat posed to our small businesses by the rising cost of health insurance. I will propose legislation that will allow small companies to join together in order to obtain less expensive insurance for their employees and remain competitive in the marketplace. This is the first of many solutions I expect to offer on this challenge during my administration.

We must also address the growing challenge in Medicaid funding, and I applaud those of you in this chamber who have spent significant time on this important issue, which—next to education—now represents the biggest single general fund program in state government. We must reform our Medicaid program to ensure its viability. But those reforms must come through innovation, new ways of thinking, and rooting out inefficiencies – not by rationing health care and services to the most vulnerable.

The federal government continues to look for ways to reduce Medicaid payments to states, mostly by cutting services to adults and children. The reality is that nearly 75% of our Medicaid budget is spent on long-term care for the elderly and disabled through a patchwork system without the benefit of care coordination or case management. Accordingly, I am directing the Department of Medical Assistance Services to develop a plan which will serve as the blueprint for moving towards an integrated, acute and long-term care delivery system for elderly and disabled Medicaid recipients. This strategy offers the promise of controlling Medicaid expenditures without curbing access to the service needed by our elderly and disabled Virginians.

Finally, we must continue our commitment to transform mental health from a service model where patients are confined to institutions, to a new paradigm where people are treated in their communities and homes. The significant mental health restructuring initiative announced by Governor Warner in December with the support of so many in this body is the right thing to do, and we need to support it in this year's biennial budget.

INTEGRATION OF ACUTE AND LONG TERM CARE SERVICES FOR MEDICAID ELDERLY AND DISABLED CLIENTS

Background

The degree of chronic illness and disability among seniors and persons with disabilities is a key policy and budget issue for the Commonwealth. The aged and disabled populations make up 36 percent of the Medicaid population in the state but 74 percent of the costs of a budget that exceeds $5 billion annually. Because of the high cost of institutionalization (exceeding $50,000 a year in some homes) and the lack of coverage for this type of care through the federally funded Medicare program, Medicaid pays for more than 2/3 of all nursing home care in the Commonwealth. Most people who enter a nursing home in Virginia either are Medicaid recipients or become Medicaid recipients once they have "spent down" their assets to pay for the nursing home care they need. For many persons, this can take less than two years.

The challenge is how to curb Medicaid growth in the long run without compromising access to services for vulnerable populations. While Virginia has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid elderly and disabled clients receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee for service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community based care providers with no overall care coordination or case management. In addition, most of the Medicaid elderly and disabled clients qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

Virginia already successfully utilizes managed care principles to coordinate the health care needs of more than 46,000 persons who are aged or disabled (including those on SSI) but who do not yet need long term care services. These clients have benefited from the various chronic disease management programs and coordinated health benefits that have traditionally been available to only low-income children and families. However, once these clients become Medicare eligible or require long-term care services they must move out of the managed care program into the fee for service program, such as nursing home or community care. This disruption of care is not good for the client and is costly for the Commonwealth

Over the past 20 years, the Medicaid managed long-term care market has grown very little, with less than three percent (fewer than 70,000 people) of the potential national market enrolled in managed care today. In spite of high interest among States in these types of programs, there have been numerous barriers in their efforts and many initiatives have been terminated during the development process. The two key barriers -- inability to combine Medicare and Medicaid funding for the dual eligible populations and lack of interest of large, national providers -- are being lessened with the implementation of new features of the Medicare Modernization Act. Through this act, States are provided with new opportunities to more easily integrate Medicare and

Medicaid covered benefits for the dually eligible populations and more national providers are considering entry into this market. In Virginia, several of the current Managed Care Organizations have expressed interest in pursuing an integrated program.

Ultimately, Virginia's Medicaid Reform should focus on the coordinated management of acute and long-term care services for the elderly and disabled as this group will have the fastest growth rate in population over the next 10 years and the largest impact on the Medicaid and Commonwealth's budget. Managed long term care programs that integrate the full range of Medicaid benefits (and Medicare benefits for those that are dually eligible) into a single program for the elderly and disabled utilize resources more effectively, improve outcomes, achieve cost containment goals, and enhances budget predictability. The movement in the direction of the integration of acute and long-term care services should be completed with careful deliberation and include the participation of all the community and state stakeholders.

Development of Short and Long Range Plans

As an initial response to Medicaid Reform in Virginia, the Governor Kaine has directed the Department of Medical Assistance Services (DMAS) to develop a long range plan which will serve as the blueprint for moving towards an integrated delivery system for acute and long term care services. This plan should be developed over the next twelve months and address the following questions:

- How will the various community and state level stakeholders be involved in the development and implementation of the new program model(s)?
- What are the various steps for development and implementation of the program model(s), including review of other States' programs, funding, populations served, services provided, education of clients and providers, and location of programs?
- What evaluation methods will be used to ensure that the program provides access, quality, and consumer satisfaction?

Concurrent with the development of a long range plan, DMAS will move forward this year with two different models for the integration of acute and long term care services: one that is locally developed with an area agency on aging and a health care system (such as a PACE site) and one that is provided through an existing Medicaid managed care organization.

Community Model. PACE is a Program of All Inclusive Care for the Elderly, which serves persons 55 and older that meet nursing facility criteria in the community, provides all health and long term care services centered around an adult day health care model, and combines Medicaid and Medicare funding. Optima (in the Tidewater area) has operated a pre-PACE model (Medicaid capitation only) since 1996 and has plans to have the full Medicare/Medicaid capitation in place by the fall of 2006. Communities in Lynchburg, Charlottesville, Northern Virginia, Tazewell, and Big Stone Gap are actively developing PACE sites. Riverside Hospital has recently joined the groups pursuing PACE. In order to move to the next step of implementation, these communities need start up funds from the State. Governor Kaine amended the budget to provide $1.5 million in start up funds for these communities.

Regional Managed Care Organization Model. Virginia has five managed care organizations that provide acute care services to more than 377,000 Medicaid clients across the State. At this time, the two largest plans, Optima and Anthem who both have Medicare plans, have expressed an active interest in developing a model that begins the integration of both acute care and long-term care services. The other three plans may also have an interest. Initially, this model would have to be voluntary for select clients until the necessary federal waivers can be obtained and the program is evaluated. This model could range from a capitated payment system (Medicaid or Medicaid/Medicare) for acute care costs only and care coordination services for the home and community based services, to a fully capitated system for all acute and long term care services. This initial program will assist DMAS in its development of a long-range blueprint for statewide integration of acute and long-term care services.